BRAIN HEALTH + BRAIN SKILLS = BRAIN CAPITAL

FINAL REPORT OF THE GLOBAL BUSINESS AND ECONOMIC ROUNDTABLE ON ADDICTION AND MENTAL HEALTH

www.mentalhealthroundtable.ca
billwilkerson@sympatico.ca
87 Augusta Street, Port Hope, ON L1A 1H1
905-885-1751

Information and Discussion Paper
by
Bill Wilkerson, Co-Founder
Global Business and Economic Roundtable on
Addiction and Mental Health
to
Yukon Government Executive and Management Seminars
'HR TRENDS AND CHALLENGES: MENTAL HEALTH IN THE WORKPLACE'
Whitehorse, Yukon,
February 11-14, 2013

1. GATHERING STORM

New findings, new trends and new opportunities are shaping an HR and management agenda for mental health in the workplace.

These trends and challenges began to unfold 15 or more years ago. In 1997-98, The Roundtable saw signs of a gathering storm.

- The rise of depression and anxiety disorders in the labour force and a sharp rise of disability insurance claims and workplace absence due to these conditions.

- An apparent shift in the profile of those who take their own lives. Suicide is now the leading cause of violent death in the world today and is the second leading cause of death among younger adolescents.

- The multiplier effect on health care costs. Due to he low rates of recognition, diagnosis and treatment of these conditions, those suffering depression and anxiety tend to flounder looking for relief.

- As a result of this, these folks use physician services, prescription drug plans and hospital services anywhere from 4 to 6 to 16 times the rest of the population. The surface symptoms may get treated but not the underlying condition.

- The invasive effects of stigma. We found that employees with depression, more often than not, were the working wounded, year after year, not knowing what ailed them, afraid to ask, afraid to tell.

- Pharmacy claims for mental disorders outpaced all other categories of group drug claims by 33%, representing more than 21% of all drug plan claims and 10% of all costs.

Concentrated in the Workplace

According to the largest-ever survey of US and Canadian workplaces commissioned by Great West Life, 18-25% of the working populations of each and both countries experiences depression each year.

We now see that depression and anxiety disorders are concentrated in the working population and that despite today's heavy focus on the aging populations as a major 'trend and challenge' in providing health care services, depression and anxiety have a decidedly young face.

Consider this:

- The average age of onset of depression is age 21, substance abuse is age 18 and anxiety disorder is age 12.

- 70% of adults diagnosed with depression have lived with their symptoms since childhood.

The sources of depression and anxiety remain scientifically unknown. But the brain-based dynamics, bodily effects and risk factors are better known.

There are major genetic and epigenetic components -- the latter referring to how our experiences in life and work influence how one's genetic disposition 'plays out' or gets expressed.

Collisions With Life

Mental collisions with our personal and working lives are one determinant of the development and onset of such conditions. Because of this, one prominent neuroscientist sees depression more like an injury than an illness.

Mental disorders are not exclusively - or even mainly - 'mental' at all. These conditions have physical properties, physical origins, and physical as well as psychological effects.

One of the myths of mental illnesses is that they are an invisible, unquantifiable phenomenon. This is not correct. So-called 'mental' disorders can be photographed via brain imaging technology.

On top of that, one day we will have a blood or saliva test for mental illnesses or the risks thereof, and we will have an x-ray for, say, depression in the form of brain imaging technology.

One of the most vivid expressions of the physical properties and impacts of mental disorders is that depression, a brain-based mental disorder, can have a dramatic impact on the course and outcome of several major – PHYSICAL – chronic conditions.

These other chronic conditions range from cardiovascular disease, arthritis and chronic pain to cancer, diabetes, asthma and head trauma.

Increased Risk of Heart Attack

Canadian clinical research has established that depression increases (among hospital heart patients) the risk of a second, sudden fatal heart attack by 500%.

Those living with depression have four times more cardiovascular disorders. Depression is an independent risk factor for stroke among women.

A new study by the London School of Economics finds that:

> "N*early a third of all people with long-term physical conditions have co-morbid mental health problems like depression and anxiety."*
>
> *"These mental health conditions raise the costs of treating cardiovascular disease, diabetes, and COPD by 45%.*

Meanwhile, ischemic heart disease and depression are on track to become the leading source of work years lost in the world economy through premature death and disability.

Depression is also associated with complications of diabetes affecting eyesight and premature death within the type II diabetes population.

In the news today are a lot of stories about concussions (athletes) and post-traumatic stress disorder (PTSD) (soldiers). Common to both are depression. And, in fact, I usually characterize PTSD as a concussion from the inside out.

In the Roundtable's final report, we conceptualized the combustible dynamics between/among these conditions as a GREAT Depression MATRIX where these co-morbidities 'zig-zag' from one to another:

- Diabetes raises the risk of dying from cancer by 25%.
- 80% of those with diabetes die from cardiovascular disease.
- Death rates among cancer patients are 39% higher among those with depression.
- In fact, cancer related depression is associated with faster tumor progression and shortened survival time

Mental illnesses including depression reduce life expectancy by 25 years and may have the same effect on life expectancy as smoking and even more than obesity.

Solving Depression: Gateway to New Health

There is GOOD news in all this. Good lord, how? Well, by solving depression – by treating it more effectively - by finding a cure --

- We will save lives from heart disease, stroke, cancer and suicide, and reduce not only the health risks of diabetes.

- We will reduce the dangers of cardiovascular disease among those living with diabetes.

- We will help reduce inflammation and the effects of chronic pain, counter the course of obesity among young adults and adolescents.

- We will protect future generations of kids against the childhood onset of depression and anxiety – and - we will reduce the risks of suicide for kids and grown-ups alike.

Massive Impact of Suicide

Let me return to the suicide question. The number of Canadians who take their own lives is equivalent to a jumbo jet filled to capacity crashing to the ground –

- Killing all on board,

- Every single month

- Of every single year

- Year in, year out.

That is, nearly 4,000 Canadians a year (ref. Yukon experience).

This cold statistic is animated by the desperate face of the youngest of the young who make this choice. The principal risk factors are so very human:

- Emotional isolation,

- Malignant loss of self-esteem and usefulness,

- The void of joblessness, grievance and rumination.

I believe we could save 31,000 lives from suicide over the next 10 years in Canada through a convergence of certain medical, social, economic, community and schools-based initiatives.

Meanwhile, 17,500 Canadians were admitted to hospital in 2010 for self-inflicted injuries and combined with 4,000 in Canada who completed this very sad task, the annual suicide burden of nearly 21,000 and individuals who have given up on life.

2. THE WORKPLACE CHALLENGE

"Mental disorders are by far the most important illness for people of working age," the London School of Economics declares. Among people at work, mental illnesses account for nearly half of all disability-related work absence in Canada.

Against this backdrop there are certain broad goals government as employer can seek to achieve.

Mental Health Goals

1. Prevent the disabling effects of depression, anxiety and substance abuse in the labour force through improved early and effective treatment of these disorders and an integrated model of disability and performance management.

2. Reduce production losses associated with employee absence and on-the-job downtime due to unchecked or advanced mental disorders especially among employees with longer terms of continuous service.

3. Promote greater awareness and vigilance among managers, employees and health professionals of the heightened risks of disability and death among employees with chronic disorders including heart disease.

4. Support efforts to create a national strategy for suicide prevention by the Canadian Association for Suicide Prevention.

Public servants are off work due to diagnosable mental disorders at a rate nearly 33% higher than the general workforce and 48% of all disability claims in the federal workplace are due to depression.

For employers in this brain-based economy, the business case for mental health is fundamentally a challenge of asset management – the asset being

- The cognitive capacity, cerebral skillsets, emotional intelligence, resilience and mental health of managers and employees up and down the organizational chart.

HUMAN BRAIN IS INTERACTIVE

Recalling an earlier point: the environments we live and work in – and the experiences we have – can affect the genetic expression of human distress which can evolve into medical symptoms we call depression and anxiety.

The human brain responds to life. It is not a fixed objective inside our skull that never changes – in fact, it can change itself (NY Times bestseller) and the way we treat each other at work is one of those influences that can alter brain function for good or ill.

WE NEED TO KNOW THAT THIS is one of the trends and challenges facing human resource management not just within the HR community but across organizations – especially at a time when new jobs by and large put an emphasis on cerebral not manual skills.

The world's first national standards for psychologically healthy workplaces were unveiled in Toronto a couple of weeks ago. Canada is leading the way in this. I commend these standards to you not as rules but as tools to do a job that needs doing.

That job is to reduce chronic job stress in the workplace as a risk factor for the kinds of health issues I am describing in these remarks. And perhaps the most deeply-seeded manifestations of chronic jib stress are embedded frustration and a sense of pervasive uncertainty on a large scale.

Isolation, Futility, Churn

The largest-ever Canadian employee survey about workplace mental health and mental illness, and specifically, depression, was commissioned by the Great West Life Centre for Mental Health in the Workplace, and conducted by Ipsos-Reid in 2007 and 2012.

This two-phased research – reaching more than 12,000 managers and employees – one third of them in the public sector – shed light on the most penetrating forms of chronic job stress - isolation, futility and churn.

We can see in ***'isolation'*** the experience of managers and employees who feel especially vulnerable in their job, cut off from the team and the future, made to feel uniquely-expendable (a few steps short of feeling rather useless generally).

We can see in **'futility'** what the dictionary says: *pointlessness.* In the workplace, this is fading or lost purpose, the chances of making one's voice heard or one's work really count are gone with the wind.

'Churn' suggests that the workplace is a 'whirling dervish' of perpetually shifting priorities, people and prospects for the employees themselves. Common in this environment is a 'hurry up and wait' management syndrome characterized by arbitrary choices and decisions.

Isolation, futility and churn constitute a state of mind individually and, on a larger scale, collectively in the workforce, and converge to embed employee frustration, generate rumination or seething and demolish trust as a condition of work.

Extended emotional isolation, embedded frustration and rumination are predictors of clinical depression, and can invade the health of the working population like a super flu bug.

At a time of severe economic uncertainty, the choices that employers make – even necessary choices – must be carried out in a manner that reflects human decency; nourishes human dignity; and recognizes the value of work done.

Building Blocks for Psychologically-Healthy Workplaces

One of the prominent 'trends and challenges' for HR practitioners and managers generally is to create a psychologically healthy workplace that unifies those things that are important to get done, and that affect employee emotional intelligence and wellbeing.

The building blocks for this alignment are ideas welcomed and planted in the soil of innovation, inclusion, employee engagement, trust, loyalty and motivation.

None of these concepts are new to the HR field. All are relevant to a work environment that promotes mental health operationally, not just through sidebar wellness programs.

The point being: mental health in the workplace is not a sidebar – not a side issue – not a 'feel good' strategy like wellness separate from the mainstream of the culture of work or the style of management practiced in the organization.

Ten building blocks which unify the principles of productive work and employee wellness:

1. Organizational objectives and expectations are well-understood.
2. Distribution of work, job skills and job expectations are well matched.
3. Employees have practical discretion and the tools to do their work.
4. Cultures of resilience replace cultures of angst and tension.
5. Resilience training becomes basic to help employees cope with change,
6. Job fulfillment is recognized as part of the employment deal.
7. Corporate values put a premium on trust and fairness.
8. Employees are encouraged, even trained to 'peer-support' co-workers.
9. Work/life balance is embodied in common sense health-first HR protocols.
10. Work culture will rein-in texting and enslavement to emails.

3. LEADERSHIP GUIDELINES

The psychological health of an individual and a work environment need not always involve medical symptoms or risks.

But the promotion and protection of mental health in the workplace overall must acknowledge and respond to medical considerations when they appear.

The World Health Organization has found that 'there can be no health without mental health.' This is demonstrated by depression's effects on physical systems in the body and the brain, and their influence on the course of seemingly unrelated illnesses demonstrate this.

In 2008, the Roundtable published and saw a healthy pick-up of guidelines for chief executive officers to help instill the psychological, managerial and health-based values in workplaces that are conducive to supporting employee health generally and mental health in particular.

Adapting these CEO Guidelines for the Yukon Government as an employer, therefore, we advise Deputy Ministers to:

- Champion mental health; do not drift from that role. Give your employees every opportunity to learn and talk about mental health.
- Embrace mental health as part of your vision for a healthy workplace
- Engage unions as full partners in the promotion and protection of employee mental health.
- Order up a complete assessment of the organization's track record in the management of employee disabilities and the prevalence of depression and anxiety (and substance abuse) therein:

    1) Audit current disability rates and procedures, and in doing so, examine each long term disability case to determine if, how and why depression is such a prominent primary and secondary diagnosis.

    2) Do a thorough cost analysis to identify productive and unproductive expenses associated with employee health generally; employee mental health in particular.

    3) Evaluate the mental health expertise and track record of service providers and assess your own management practices with those identified as most likely to precipitate/aggravate mental health problems among employee

    4) Make line executives and managers accountable for outcomes of disability management policies and practices.

    5) Ensure HR staff has the competence/aptitudes/attitudes to deliver well-informed, non-judgmental, non-bureaucratic, empathetic HR policies/ practices.

    6) Governments as employers must find out if they are up to date on the latest mental health data and how they evaluate the mental health services of the various vendors.

    7) Governments as employers are advised to conduct an employee awareness program about depression, anxiety, and substance abuse.

Further:

Governments as employers must educate managers about mental illnesses and train them in how to react to employees they suspect may be suffering in this way or displaying emotional distress.

An impressive tool is “Guarding Minds at Work” which is available online at Great West Life Centre for Mental Health in the Workplace.

Governments as employers can offer mental health screenings. Early identification of mental illnesses can save money, and screening for mental illness is one of the most effective tools employers can use to cut costs.

Governments as employers could “path-find” by testing depression screenings in the public sector workplace and help people understand that they can be screened for depression in the same way that they can be screened for high blood pressure.

Governments as employers are well-advised to examine carefully the administrative or insured services provided by insurance companies or case management providers. Know what you are purchasing and why.

Employers (public and private) often make 'buy' decisions around disability insurance policies, for example, that have unintended consequences that can limit employee eligibility when this is not the employer's objective. Remember this: the insurance company works for you, not the reverse.

Concrete Goals

The workplace of government will require a 'modern model of leadership' where Deputy Minister**s** recognize the link between a healthy culture and healthy employees and take an investment approach to spending on employee health benefits and reforms.

4. DISABILITY MANAGEMENT TARGETS

Reasonable targets to guide disability management and prevention programs in the workplace of government:

1. Reduce absence related costs due to mental disabilities – including wage replacement and on the job downtime – to 3% of annual payroll.
2. Reduce mental disabilities as a proportion of the total disability experience from the current 40% range to single digits in 5 to 8 years.
3. Achieve a 95%+ success rate for returning employees to work from depression, sustaining that over six months.

In the workplace of government, disability case management should be anchored by what I call an '*Employee Asset Renewal Process'* which progresses from illness and disability, through to symptom-remission, recovery of functional health and gradual return to work – all as a form of asset protection.

Containment of chronic stress in the workplace of government is all important:

- Root out management practices which are endemic sources of chronic job stress and most likely to precipitate or aggravate chronic health problems including depression and anxiety.

- Arm employees with the information they need to play their part in reducing the effects of chronic job stress on their own health and performance on the job.

- Clear up the confusion about what "good" and "bad" stressors are – what job stress is and is not – why some kinds of stress affect some people and not others.

- Train managers to be alert to the effects of chronic stress on employees – most particularly, women who are pregnant and still working.

- Focus on the secondary prevention on the early identification, detection and intervention leading to early access to care and treatment for bona fide symptoms of mental disorders. Use the Roundtable's Rule out Rules:

Compounded Disability Rates

The longer an employee is off work, the less likely he or she will ever return to the job. The 2006 Plan sets out some "rule of thumb" guidelines.

Early Intervention is Key

If depression is caught and treated inside 12-weeks vs 18 weeks, an employee's time off work can be cut in half(Greenberg et al).

Right Treatment is Key

Employees who are prescribed recommended medications for depression are significantly more likely to return to work and not drift into LTD (Dewa et al).

In pursuit of these aims, I offer the following discussion of workplace stress that reflects years of Roundtable experience.

5. THE STRESS INVASION

What Stress Is

- Stress is not all bad, or all good. Some keeps us on our toes. Too little makes us disinterested. Too much – even of a good thing – can upset our well-being.

- Stress is not a state. It is a process, a set of variables; it's how we react to circumstances at work or in life, an individual experience.

Physical Basis

- There is a relationship between stress, the nervous system and brain regulation of the cardiovascular system. This demonstrates the physical basis of stress-related problems including depressive disorders.

Two Kinds

- There are two concepts: disruptive stress and constructive stress. Otherwise stated, anxiety stress and motivation stress.

- Human beings have a protective mechanism which alerts us to withdraw when the anxiety form of stress faces us. Uncertainty is one source of this kind of stress.

Stress Traps

Stress can become dysfunctional over time when:

- The skills of the individual and expectations of their boss and the demands of the job and resources available to do it are not aligned.

- Workplace practices seem routinely unfair or illogical.

- The "struggle to juggle" obligations at home and work never let up. Job and home stress are synergistic.

- Workplace stress intensifies near the close of the workday and is taken home. According to the Institute for Work and Health, this poses a greater risk to the cardiac health of people than smoking**.**

- When job stress becomes chronic, it can:

    - Override our natural defences to ward off infection and viruses, escalate the production of inflammatory hormones that drive heart disease, obesity and diabetes, spark flare-ups of rheumatoid arthritis, trigger depression.

    - Escalate hormonal release which boosts our heart rate, blood pressure, breathing and blood flow to our muscles. This is OK from time to time and for limited periods. But not continuously.

    - Cause accidents on the job. Stress, a trigger for depression, fuels and feeds off sleep deprivation and lost concentration.

Ten Faces of Stress

A "Stress Policy" should help employees (including executives) to recognize what unhealthy stress looks like. It has a face – in fact, 10 faces:

1. Growing irritability and impatience, "no end in sight" reactions to even routine requests for information.

2. Inability to stay focused, finishing other people's sentences to "save time," wincing at new ideas (who needs another new idea), being unable to sit still, looking distracted and far away.

3. Staying out of sight, keeping the world at bay, being testy about casual interruptions such as a phone ringing, not looking up when talking to others.

4. Treating the concerns of others about workload and deadlines with contempt and "join the club" sarcasm.

5. Displaying frustration with one's own boss in the presence of others and leaving angry voicemails after regular business hours.

6. Stretching the workday at both ends, calling in sick a lot, persistently late for meetings.

7. "Working at home" to avoid the negative energy of the office.

8. Limiting eye contact with others except to "react," finding it painful to smile openly, your cheeks heavy, a fuzzy feeling behind your eyes.

9. Finding small talk hateful. Tuning-out what others say. Missing deadlines, losing faith in yourself and others, resenting and even alienating customers.

10. Eventually, physical symptoms of pain and burning, breathing troubles, back problems. Burn-out may migrate to a diagnosable and dangerous medical condition.

Management Practices

Certain management practices should be modified to reduce the triggers of unhealthy job stress by:

1. *Continuous imposition of unreasonable demands on subordinates and withholding information that is materially important to them to carry out their jobs.*

2. *Refusal to give employees reasonable discretion over the day-to-day means and methods of their own work and failing to credit or acknowledge success.*

3. *Rejecting "out of hand" employee workload and deadline concerns and creating a treadmill effect in the allocation of work and priorities.*

4. *Pushing unnecessarily tight deadlines as a force-feeding technique and talking personally to direct reports only when there's a problem and, in doing so, creating an email-only culture.*

5. *Changing priorities without notice or reason, tolerating ambiguities in work assignments, expectations and outcomes. Meaningful job descriptions and annual performance reviews are an anachronism in this environment.*

6. *The treadmill effect at work – one deadline morphing into another and draining the work experience of its essential "job fulfillment" quota.*

Personal Employee Responsibility

A series of questions will help employees themselves evaluate the kind of stress they are experiencing at work – for example:

- Does the job at hand call upon the skills, time and resources I actually possess?
- Conversely, do I feel responsibilities piling on and resources disappearing?
- Does my job right now create the opportunity for fulfillment of some sort?
- Do I feel I can contribute – or is this just a treadmill I'm on?
- Do I realistically think the job I'm doing right now will add up to something?
- Do I realistically think the job I've been given to do under deadline can be successfully completed and recognized as such?
- Does the task at hand flow from a job that is meaningful?

Managerial Responsibility

Lower job stress in the work environment**:**

- Determine if employees are stretched too far.
- Determine if roles and expectations are unclear to them.
- Determine what tools to do the job of the returning employee are needed or lacking. (This includes information, budgets, technical and people resources
- Provide constructive feedback and (when the opportunity presents itself) – recognition.

Be aware of your (returning) employee's wellbeing. Notice changes in behaviour and attitudes.
HR Managers: educate your leaders and managers**:**

- Their responsibilities to their direct reports under human rights rules.
- Their obligations of performance management.
- What chronic stress is and is not.

How to handle relapse (notification of extended absence)

- Express empathy and concern.
- Has the individual seen a doctor; how long does the doctor say the additional time away will be?
- Advise that you will be sending paperwork the physician will need to fill out.

Managers managing the return to work process itself:

- Conduct team meeting and brief co-workers on the employee's return.
- Do not talk about limitations. Talk about "the job" and getting back in the saddle.
- Brief co-workers (briefly) on the modified duties and make it clear this job accommodation process is both smart and necessary.
- Ensure no single person or group bears the lion's share of the work transfer necessitated by the job accommodation process.
- Interview the returning employee:
    - Welcome back
    - Update on the company
    - Review the job/modified duties
    - Invite the case manager to come in
    - Discuss accommodation requirements
    - Set dates and times for reviewing progress and problems
    - Make a two-way "feedback understanding." This is absolutely key.
- Express personal support and establish clearly that the employee's return to full-time employment is the ultimate goals

- Create a “clean slate” performance record. This is smart and appropriate.

CFO Framework

The Roundtable also produced a CFO Framework for Mental Health and Productivity and this is easily adapted for problems the financial executives of government as employer may have. The purpose: to determine, track and resolve where the costs of mental health occur.

Certainly wage replacement costs and payroll redundancies as a result of shoring up the lost capacity of absent employees are significant. Other costs may take these forms:

- Employee benefit and disability costs
- Liability exposures (tax, legal, pension, severances)
- Unfunded (unplanned) downtime and lost capacity
- Intransigent service problems
- Sluggish receivable collections
- Team management problems
- Spending inconsistencies
- High turn-over

For example: government CFO’s are advised to explore how and where the costs of absences, downtime and both short and long-term disability claims – plus group health usage – attributable to depression and other chronic conditions accumulate.

For example:

- The cost of mental health in the workplace can be directly and indirectly linked to both `revenues (taxes and fees) and expenses (collections)

- Government departments and agencies that do not track mental health costs may have unfunded liabilities not reflected in financial statements.

Specific Cost Categories

A basket of financial categories illustrate where these costs may be tracked and back-tracked to ensure that organization has a clear picture of rates of absence due to mental disorders - principally depression – and how those costs are managed:

CFO Cost Management for Mental Health in the Workplace

Baseline Cost Metrics

1. Extended/Group Health Care Costs
    - drug claims by major drug category
        - per covered active employee
    - mental illness related drug claims as a percentage of total drug claims
        - per covered active employee
    - number of mental illness related drug claims
    - number of mental illness related drug claims where a second drug is also being claimed for another ailment (co morbidity)
2. Employee Assistance Costs
    - number of employees using the program for mental illness related disorders (utilization rates)
        - utilization as a percentage of total program users
    - number of cases referred to community based treatment programs
    - number of high risk mental related cases
3. Absenteeism Costs
    - lost workdays (paid and unpaid) per active employee
    - lost workdays (paid and unpaid) for mental illness related disorders as a percentage of total lost workdays per active employee
    - absenteeism rates by type of ailment/disorder
    - average duration of absenteeism
4. Replacement Worker Costs
    - total cost of replacement workers
        - as a percentage of total active payroll costs
    - number of replacement workers (full time equivalent) used per reporting period
    - employee turnover rates relating to mental health disorders
5. Short and Long term Disability Costs
    - number of short term disability claims related to mental health disorders
        - as a percentage of total short term disability claims
    - number of long term disability claims related to mental health disorders
        - as a percentage of total long term disability claims
    - average duration of short and long term disability claims relating to mental health disorders
    - cost per claim of short and long term mental health related disorders
6. Presenteeism Costs
    - the actual output per worker as a percentage of targeted output per worker
        - quality of output (e.g., defect rates, customer feedback, etc.)
    - actual vs. targeted [or top 50^{th} percentile] worker output percentage times the total active payroll cost
7. Productivity is generally measured as total revenue or profit per employee. Other measures: increased sales and improved customer and supplier satisfaction.

Other Metrics

The dynamics behind cost fluctuations in these categories are:

- The frequency and cost of depression / anxiety / relate claims among their employees is increasing.
- Over 10% of general drug plan costs are for mental illness drugs and over 21% of all drug claims are to treat mental illness.
- When medical conditions co-occur with mental illness, specifically depression, total pharmacy costs related to mental illness increase by a factor of three.
- The number of mental illness-related pharmacy claims increased 5.4% from 2004 to 2005, as compared to a total pharmacy claims increase of 3.8%.
- Absence/disability costs which exceed 3% of payroll.

6. CONCLUSION

Reference: Bill Wilkerson, Co-Founder, Global Business and Economic Roundtable on Addiction and Mental Health – 905-885-1751 – billwilkerson@sympatico.ca